PLEASE READ CAREFULLY BEFORE SIGNING

Authorization for Medical and/Or Surgical Treatment

This is to certify that I, the undersigned hereby consent to and authorize the administration and performance of all treatment and which in the judgment of the attending physician/practitioner may be considered necessary or advisable. I also authorize treatment of any of my minor children herein listed.

Insured's Signature_____Date_____

AGREEMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible amount, co-insurance, or any services deemed as "Non-Covered Benefit" by my insurance carrier. A finance charge of 1.5% per month/APR 18% may be added to any amount for which payment has not been received within 30 days from the date of service. I agree to pay a $20.00 service charge for any returned check as unobtainable. Also if any check is returned as unobtainable, any discounts given to me at the time the check was issued shall be void and such discount shall become due and payable.

INSURANCE BILLING

In the event that I have a third-party payer herein listed, I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid Private Insurance and any other health plan to **Health Clinics of Utah.** This assignment will remain in effect until revoked by me in writing, A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said third party payer. I hereby authorize said assignee to release all information necessary to secure payment.

I agree to notify **Health Clinics of Utah** in writing of any changes in employment, address, marital status, insurance carrier(s), insurance coverage, minor children and/or dependents herein listed as beneficiary, minor children on their 18th birthday, or minor children no longer living at my residence. I agree to relate this information to **Health Clinic(s) of Utah** within 30 days of such event (s) occurring.

GOVERNMENTAL IMMUNITY. All claims for negligence, and other claims against Health Clinics of Utah and its employees, including physicians, nurses, technicians and students, may be governed by the provisions of the Utah Governmental Immunity Act, Section 63-30-1 et seq. Utah Code Annotated, 1953 as amended, a. There are special laws governirestricting how and when a claim must be presented and limitations on the amount recovered.

I acknowledge that I have carefully read that above and hereby agree to the terms and conditions as set forth. I have had the opportunity to ask questions and if so, understand the answers.

_____ _____

Signature of responsible party Date

_____ _____

Witness Date